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Thank you for the invitation to present to you information on the financing and governance of local health departments. I am going to provide the Commission with an overview of the structure and the funding history of local health departments. Every county in California, and three cities, have local health jurisdictions, which provide a variety of public health and indigent health care services to their residents. Though local health departments have long been the primary providers of public health services, the methods of financing these services has varied over years, often in response to changes in the political winds, such as the passage of Proposition 13 in 1978.

Over time, there has also been increasing diversity among counties in the organizational structures by which they carry out their responsibilities in various health programs, including the provision of public health services. There are generally three models of organization at the local level: 1) stand alone Public Health Departments, 2) Health Care Agencies (which also include indigent health care and may include mental health and drug and alcohol departments), and 3) Health and Human Services Agencies. Whatever the structure of the department, the director of a local health department ultimately is accountable to the County Board of Supervisors (or City Council) for the administration of public health programs. Counties are locally accountable political subdivisions, and they are also accountable to the state for the activities funded by the state, regardless of whether that funding is adequate.

With the exception of a relatively small state public health subvention, public health services were historically funded at the local level through property taxes. With the passage of Proposition 13 in 1978, the ability of local governments to fund essential public health services was significantly impacted. The California Legislature recognized this and created, through AB 8 (Chapter 282, Statutes of 1979) a block grant program to backfill the public health funding lost to local governments. Use of these funds was restricted to programs that each county had funded prior to Proposition 13, which included such things as public health nursing, epidemiology, health education, public health laboratories, and in some counties, animal control. Counties continued to share in the funding of these services, through their Maintenance of Effort (MOE), in which they were required to spend a minimum amount in order to receive their full allocation of state funds.

In the continuum from traditional public health to personal health care, the line between the two is often very blurred. The interconnection between them is reflected in the funding of local health services. For example, inter-related to the AB 8 public health funding were changes in the funding of Medically Indigent Adults (MIA's). Since the state could not receive federal matching funds through the Medi-Cal program for these individuals, the state transferred responsibility for their care back to the counties during

the state budget crisis of 1982. However, counties were only given 70% of the funds the state had spent serving this population. This funding level was further reduced in later years. Large counties provided services under the Medically Indigent Services Program (MISP), while smaller counties were allowed to contract back with the state to provide services under the County Medical Services Program (CMSP). Inadequate funding for these MIA programs was one of the reasons that the Legislature dedicated a portion of Proposition 99 (The Tobacco Tax and Health Protection Act of 1988) funds to create the California Healthcare for Indigents Program (CHIP) and Rural Health Services (RHS) program.

The restructuring of state and local financing in 1991 known as Realignment resulted in the AB 8 public health block grant program being rolled together with funding for the medically indigent adult (MISP and CMSP) programs. Health Realignment dollars can only be used to fund either indigent health care or the old AB 8 programs; county general fund matching requirements for these programs remain. For the 34 small counties that pool their funds to provide indigent health care through the CMSP, approximately 70% of their Health Realignment funds go directly to the CMSP program and the remaining Realignment dollars are used primarily for public health. The larger counties must struggle every year to allocate their Health Realignment funds between the equally compelling needs of public health and indigent health care. Further exacerbating this funding tension has been the drastic decline (from nearly $350 million in 1990 to $69 million this year) in Proposition 99 county indigent health care funds. In addition to the Health Realignment funds, Realignment funds are also used to fund county mental health programs as well as some social services programs through separate allocations.

Counties receive approximately $1.3 billion statewide in Health Realignment dollars. Additionally, counties receive approximately $1 million in State Public Health Subvention for communicable disease control. Health departments also administer a number of categorical public health programs that are funded, by either the federal or state government. Examples of these types of programs are the federal Ryan White AIDS and Maternal and Child Health (Title V) programs and the state Child Health and Disability Program (CHDP), Tobacco Control, nutrition services and preventive health care for the aging. Realignment funds are also used by counties to backfill categorical program funding, which is increasingly inadequate to cover growth in these programs.

Finally, the ability of counties to augment public heath funding from local sources was severely impacted by the shift of property tax shares from counties to schools in FY 92-93 and FY 93-94. This shift, which continues to this day, now totals approximately $3.5 billion annually from counties.

As an indication of the breadth and complexity of categorical programs administered by local health departments, a recent tally by CHEAC indicates that some local health departments submit over one hundred program and fiscal reports to the State each year.

Local health departments demonstrate on a daily basis their dedication to improving the health of all Californians. We appreciate the Commission's attention to this important work.